AvMed
SELF-FUNDED SOLUTIONS

Affidavit of Extended Dependent Eligibility

I, _____, hereby swear or affirm that I am the legal parent of
(Subscriber's Name)

_____.
(Child's Name)

I further swear or affirm that the child named above is between age twenty-six (26) - thirty (30) and:

- Is unmarried and does not have a dependent of his/her own; and
- Is a resident of Florida or a full-time or part-time student; and
- Is not provided coverage as a named subscriber, insured, enrollee, or covered person under any other health plan or insurance policy and is not entitled to benefits under Medicare.

I understand that I have provided this information for use by AvMed Health Plans for the purpose of determining eligibility for participation in my group health plan by the dependent named herein. I further understand that AvMed Health Plans reserves the right to request proof of child's status.

I affirm that the information in this Affidavit is true to the best of my knowledge and belief. I understand that any intentional misrepresentation by me in this Affidavit may result in retroactive termination of coverage under the Group Health Plan and retroactive denial of claims previously processed for my child, in which case I will be responsible for the cost of all claims incurred.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. F.S. Section 817.234 (1)(b).

_____
(Subscriber's Signature)

Subscribed and Sworn/Affirmed personally before me, a Notary Public, on this _____ day of _____, 20__

by _____, who is personally known to me or who has
(Subscriber's Name)

provided satisfactory proof of identification.

_____
Notary Public

My Commission Expires_____